State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
TNPL537218	A. Building B. Wing	6/21/2011

Name of Facility	Street Address, City, State, Zip Code
MARY, QUEEN OF ANGELS	34 WHITE BRIDGE ROAD NASHVILLE, TN 37205

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **D0713** Reg. # **1200-08-25-.07 (7)(a)1.** LSC	Correction Completed **06/21/2011**	ID Prefix **D0832** Reg. # **1200-08-25-.08 (9)(b)** LSC	Correction Completed **06/20/2011**	ID Prefix **D1216** Reg. # **1200-08-25-.12 (3)(a)** LSC	Correction Completed **06/20/2011**
ID Prefix **D1223** Reg. # **1200-08-25-.12 (5)(a)** LSC	Correction Completed **06/21/2011**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By PDC	Date: 7/7/11	Signature of Surveyor: Lynette Jones / PDC	Date: 6/21/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
3/30/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537218	A. BUILDING _____ B. WING _____	C 03/30/2011

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D 713	1200-08-25-.07 (7)(a)1. Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with at least the following personal services: 1. Protective care; This Rule is not met as evidenced by: INTAKE #TN00024928 Based on record review, document review, observation and interview, it was determined the facility failed to protect 5 of 6 (Resident #1, 2, 3, 4, and 5) sampled female residents from the inappropriate sexual behavior of a cognitively impaired male resident (Resident #7) over a period of months and failed to enhance self-esteem and self-worth, promote dignity and respect for private space and prevent further potential for demonstration of socially inappropriate touching of female residents by failing to manage the sexually aggressive, inappropriate and intrusive behavior of the male resident. The findings included: 1. Medical record review for Resident #1 documented an admission date of 3/27/06. Diagnoses include dementia, osteoporosis, duodenal cancer and Breast cancer. The resident resided on the South (secure) wing until her death in July 2010.	D 713	The facility will ensure that whenever any incident(s) of resident to resident abuse is discovered or reported, all appropriate measures are taken to protect and obtain the appropriate medical evaluation for the victim(s) if necessary. The incident(s) will be documented in both the victim(s)' and perpetrator(s)' record and the resident(s)' physician and responsible party notified of the alleged incident in a timely manner. The incident(s) will be reported to the proper authorities when warranted. The facility will also work diligently to obtain the appropriate psychiatric and /or counseling service to develop a behavioral modification plan to be implemented by the facility. The staff will be in-serviced thoroughly regarding the behavioral modification plan which will be documented. Also, any counseling provided to the resident(s) will be documented in their medical records. Date of Completion May 15, 2011 This will be monitored by the Director of Nursing, Resident Services Director and the Executive Director	

Accepted 4/27/11 - PDC

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D 713	Continued From page 1 2. Medical record review for Resident #2 documented an admission date of 9/6/09. Diagnoses include musculoskeletal pain and chronic bronchitis. The resident resided in the non-secure area of the ACLF. 3. Medical record review for Resident #3 documented an admission date of 4/8/03. Diagnoses include dementia, early Alzheimer and depression. The resident resided on the South (secure) wing. 4. Medical record review for Resident #4 documented an admission date of 5/1/07. Diagnoses include hypertension and dementia with mixed Alzheimer type. The resident resided on the South (secure) wing. 5. Medical record review for Resident #5 documented an admission date of 2/22/08. Diagnoses include early dementia and degenerative arthritis. The resident resided in the non secure area of the facility. 6. Medical record for Resident #7 documented an admission date of 11/15/06. Diagnoses include dementia of Alzheimer type with depression and behavioral disturbance and a history of cerebral vascular accident, coronary artery disease, hypertension, diabetes mellitus and epigastric pain. The resident was originally admitted to the non-secure area of the facility but was moved to the South (secure) wing on 8/27/08 where he resided until 2/11/10. The Quarterly Assessment for Level of Care dated 11/2/09, 1/30/10, 5/19/10 and 8/20/10 documented the resident was independent for mobility and eating, occasionally incontinent,	D 713		

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D 713	Continued From page 2	D 713		

required verbal prompts with personal hygiene and some hands on assistance with bathing and dressing. Psychosocial Status was circled for, "Occasional verbal direction to maintain appropriate social and personal behavior."
The Quarterly Assessment for Level of Care dated 11/17/10 documented Psychosocial Status as, "Extensive intervention and supervision to manage inappropriate behavior toward self and others and to develop very basic social skills."

The Plan of Care Form dated 9/16/08 documented the resident resided on the secure wing and should be checked every 2 hours. A handwritten note at the top left of the page and dated 10/22/09 documented the resident was to be checked every hour to, "Be sure he is not in someone else's apartment. There were no interventions documented to guide staff should the resident be found in another resident's apartment or should inappropriate behavior be observed.
The Plan of Care form dated 2/15/10 documented the resident resided in the non-secure area of the facility. The bottom of the page contained a handwritten note documenting, "Due to inappropriate behavior to others at times - monitor closely and document." There were no interventions documented to guide staff should the resident display inappropriate behavior.

A Nurse Note dated 8/19/09 documented the resident was found in a female resident's room displaying inappropriate touching.
A note signed by the Resident Service Director and dated 10/21/09 documented that at "...7AM ish " Resident #7 was not in his apartment and that he was he was found in Resident 4's apartment. He was told to go back to his apartment and did. According to the Resident

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D 713	Continued From page 3 Assistant (RA) on duty he attempted to go back into Resident #4's apartment 2 times before the RA left her 7:00 AM to 3:00 PM shift and he was told again he could not go in that apartment . Another RA came on shift at 3:00 PM and was met in the hallway by the off going RA who stated Resident #7 was in bed with Resident #4, he had been in Resident #4's room 3 times and he had stated, "keep the incident a secret." Review of a fax communication from the facility Nurse Director (ND) dated 10/21/09 documented, "...COMMENTS: Resident is displaying inappropriate sexual behavior toward female resident in the memory impaired unit which is sometimes forceable. May we have something to calm these behaviors?" Another entry dated 1/21/10 documented the resident was seen by staff inappropriately touching a female resident. Staff stated the resident had the female resident's (Resident #1) incontinence brief and her pants pulled down and he was fondling her. On the same day a telephone call was made to the resident's physician requesting he be sent to an inpatient psychiatric facility due to, "inappropriate sexual behavior towards a female resident ..." The resident was transferred to the psychiatric facility the same day. The Discharge Summary from the psychiatric facility dictated 2/9/10 documented Resident #7 was discharged to the medical unit on 2/8/10 due to upper epigastric distress but had been stabilized prior to transfer. Discharge medications included Seroquel 100 milligrams (mg) (increased from 25 mg) at bedtime. The resident was also taking Celexa for depression and Aricept for dementia and memory. Nurse Notes dated 2/11/10 documented Resident #7 returned to the ACLF and was placed into the	D 713		

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D 713	Continued From page 4 non-secure area of the facility. Nurse notes dated 2/13/10 documented the resident was having signs and symptoms of weakness and unsteady gait, the caregiver (RA) was instructed to hold the seroquel and Physician #1 (the attending physician) was faxed. A faxed document from the ACLF dated 2/15/10 to Physician #2 (the physician for the psychiatric facility) documented, "The facility is requiring a written treatment plan as to what interventions will be taken if the current medications doesn't control the inappropriate behaviors ..." Another faxed document from the ACLF dated 2/16/10 to Physician #2 documented, "I need to clarify my request. The facility is needing your treatment plan of what intervention(s) you plan on taking should the current medications fail to control the inappropriate behaviors ..." A faxed document from Physician #2 dated 2/16/10 documented, "If current somatic interventions are not successful, I suggest re-hospitalization and initiation of hormonal therapy." A letter addressed to the ACLF Administrator from the Nursing Director (ND) dated 2/17/10 documented, "This is a summary of the meeting ... following my reassessment visit with [Resident #7] on 2/03/10. During this meeting we discussed whether or not [Resident #7] would be appropriate to return to the facility ... he had displayed no inappropriate behavior of any kind ... had been started on a new medication and the dosage of another medication had been increased to help alleviate and control the inappropriate behaviors ... It had been decided that [Resident #7] would be allowed to return to the facility on his the treatment he was currently receiving at the hospital ... It was also agreed upon that he would be moved from the memory impaired unit [secure wing] to the main house	D 713		

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D 713	Continued From page 5 [non-secure area] before returning to the facility." A Nurse Note dated 2/18/10 documented the resident had a physician's appointment and the Seroquil had been decreased to 50 mg at bedtime. A Physician Visit Summary signed by Physician #1 documented the Seroquel was to be decreased to 50 mg at bedtime (one half the prescribed dose at hospital discharge). Nurse Notes dated 3/4/10 documented Resident #7 "...was observed being sexually inappropriate with a female resident [Resident #3] during an activity function yesterday [3/3/10] ... was observed kissing resident on the mouth and fondling her breast ... [Physician #2] to be notified." Nurse Notes dated 3/5/10 documented, at 9:00 AM faxed Physician #2 regarding incident, at 11:30 AM fax received from Physician #2 requesting Durable Power of Attorney for Health Care (DPOAH) contact him to discuss resident. At 12:15 PM spoke with DPOAH and informed him of the incident involving this resident being sexually inappropriate with a female resident, and that Seroquel had been reduced from 100 mg to 50 mg during a visit with the Primary Care Physician (Physician #1). The DPOAH stated he had spoken to Physician #2 and he was reluctant to start hormonal therapy due to Resident #7's advanced age. Suggested DPOAH ask Physician #1 (attending physician) to increase Seroquel again as maybe since being decreased 2/18/10 it is not achieving the therapeutic benefits... will continue to monitor." A Physician Visit Summary dated 3/18/10 documented under CHANGES IN MEDICATIONS, "No Changes."	D 713		

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D 713	Continued From page 6 Nurse Notes dated 4/11/10 documented Resident #2 stated when she was waiting on the elevator, Resident #7 walked up behind her, turned her head to the side, grabbed her and kissed her. The noted documented that Resident #7 denied doing anything wrong and that caregivers (RA's) were instructed to monitor the resident ' s behavior closely. Review of RA notes dated 4/11/10 documented, "...approx.[approximately] 2:30 pm [Resident #2] was on the 2nd floor reading the Info board [Resident 7] came out of his room from sleeping and asked caregiver what time supper begins [Resident #2] proceeded to the elevator & [and] [Resident #7] approach, I heard [Resident #2] say stop, so I went to...what was going on...[Resident #7] trying to kiss her though [Resident #2] kept saying STOP, he [Resident #7] kept trying. I sounded my voice to [Resident #7] and told him to stop but he didn't. The caregiver then had to shout out to him & [and] of course the he listening...[Resident #2] said she was okay but ' hated how that man approached her. ' " Nurse Notes dated 4/12/10 documented Resident #7 was inappropriately touching and trying to kiss Resident #3 "against her permission." 7. Review of a facility incident report dated 1/21/10 documented Resident #7 was seen in a female resident's (Resident #1) room and that he had the female resident's incontinence brief and pants pulled down and was fondling the resident. The TYPE OF INCIDENT section of the form documented, "Sexual Assault." The Recommended steps to prevent recurrence section documented, "Resident told that he cannot fondle other residents as this is inappropriate behavior, also told resident that his actions can be serious."	D 713		

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D 713	Continued From page 7 Review of a facility incident report dated 4/11/10 documented Resident #2 stated that while she was waiting for the elevator Resident #7 walked up behind her, grabbed her head, tuened it to the side and kissed her. When Resident #7 was asked about the incident he stated he didn't do anything. The TYPE OF INCIDENT section documented, "Inappropriate behavior." The Recommended steps to prevent recurrence section of the form was left blank. Another incident report for this incident was present for Resident #2. Review of a facility incident report dated 7/30/10 revealed therapy staff reported Resident #7 "was noted kissing another resident [identified by facility as Resident #5] inappropriately in the hallway. Resident denies doing anything wrong & [and] doesn't recall the incident... Reminded resident that he is priest & [and] should not behave inappropriately" Information for this incident was not found in the resident's chart. 8. Observations of Resident #7 on 11/2/10 at 11:03 AM, while attempting an interview with the resident, revealed he answered the door with his pants and incontinent brief down around his ankles, he stated he was coming out of the bathroom. When the surveyor offered to wait outside the door until he could pull up his pants he stated, "You can come on in." The surveyor offered again to wait outside and pulled the door closed. Resident #7 returned to the door with pants pulled up and asked, "Who are you?" After the surveyor stated her name and the purpose of the visit, Resident #7 stated, "I have no strength to talk... I don't want to talk to you." 9. During an interview on 3/29/11 at 11:15 AM,	D 713		

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D 713	Continued From page 8 the facility Activity Director (AD) was asked what she recalled about the incident she observed on 3/3/10. The AD stated, "We had to make a plan to keep him [Resident #7] away from her [Resident #3], he would kiss her, rub her shoulder, upper thigh, hair, chest area..." The AD clarified that Resident #3 was in the South unit at the time but they were brought out to an activity with the residents living in the non secured area where Resident #7 resided. She further stated, "I can remember getting someone to pull [named Resident #3] out of the activity. When asked if she had ever seen this before, the AD stated, "No, it was just with her [Resident #3]. 10. During an interview on 3/30/11 at 9:30 AM, RA #1 was asked to recount what she recalled regarding incident on 1/21/10. The RA stated, "On the memory care unit in resident room, I'm doing something and I heard Resident #1 crying, went into room, Resident #1 pant is down diaper is pulled down, told Resident #7 to leave her alone...Resident #7 said 'I'm just helping her to bathroom, you don't have to help her.'.." When asked if Resident #1 was able to tell her what happened, RA #1 stated, "No is confused...just crying..." When asked if she had ever seen Resident #7 exhibit behaviors, RA #1 stated, "Just giving hugs and kisses like in a friendly way...like with [named Resident #3]..." RA #1 further stated she did not work with Resident #7 after the incident because he was moved out of the secure wing. 11. During an interview on 3/29/11 at 10:45 AM, the Executive Director (ED) reported the actions taken by the facility for Resident #7 was to remove him from the secure wing and counseling by nursing staff.	D 713		

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D 713	Continued From page 9 During an interview on 3/29/11 at 2:45 PM, the ED stated the Bishop who was also Power of Attorney for Resident #7 had been to talk with him about the inappropriate behaviors, and they were considered interventions that had worked. During a subsequent interview on 3/30/11 at 10:55 AM, the ED confirmed that these meeting were not documented. During an interview on 3/30/11 at 9:55 AM, the ED was asked if Resident #7 had been provided any counseling services through the facility's gero-psych provider related to these incidents. The ED stated, "We are trying to find a Polish speaking translator... wanted to make sure he was understanding counseling ... not successful at finding anyone..." The surveyor showed the ED and ND that Resident #7 had documented counseling services in 2007 and 2008 with no interpreter required. 12. During an interview on 3/29/11 at 10:55 AM, the Nursing Director (ND) was asked to clarify what the term, "sometimes forceable" meant. The ND stated, "walk up to... kiss them and hold them, that's before I knew about his culture [Resident #7]... they kiss each other in his culture [Polish]... grab by each arm and kiss..." During an interview on 3/29/11 at 11:05 AM, the ND stated the Seroquel was reduced because it was making Resident #7 lethargic, it was a safety issue and Physician #1 [attending physician] reduced it to 50 mg. When asked if he had a concern regarding the medication reduction, the ND stated, "Yes, because that was what they stabilized him on in the hospital." The ND confirmed Resident #7's dose of Seroquel had remained 50 mg since the reduction on 2/18/10. When asked if there was communication	D 713		

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between the 2 treating physicians, the ND stated, "I don't know that's pretty much where the communication stopped." When asked if there was any facility communication with his attending physician regarding the concern that the Seroquel reduction may have affected the increase in documented behaviors, the ND stated, "No I assumed he [Physician #2] went with [Physician #1] to decrease the Seroquel because he was lethargic."

During an interview on 3/29/11 at 11:30 AM, the ND verified there were no reported incidents since 7/30/10. When asked how they had addressed the inappropriate behaviors with Resident #7, the ND stated, "...all along telling him you ' re a priest ... told him can't touch, kiss without asking ..."

During an interview on 3/30/11 at 10:05 AM, the surveyor asked for documentation of the one to one counseling done by the ND with Resident #7. The ND stated there was no documentation, that it was more informal, in the hallway if maybe Resident #7 had his hands out to hug.

During an interview on 3/30/11 at 10:40 AM, the ND stated, "Any behavior modification plan would have been done at the hospital [hospitalization 1/21/10] no plan in writing..."

Resident #7 had documented inappropriate behavior beginning in August 2009 that continued through July 2010. The facility failed to initiate interventions for Resident #7 to effectively manage his unwanted sexually inappropriate behavior and thereby provide protective care for the female residents of the facility.

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D 832	Continued From page 11 1200-08-25-.08 (9)(b) Admissions, Discharges, and Transfers (9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents at its annual survey: (b) Ongoing and up-to-date documentation that each resident ' s interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure families were included in each resident's interdisciplinary team (IDT) quarterly review as to the appropriateness of placement in the secured unit for 4 of 4 (Resident #1, 3, 4, and 7) sampled residents currently or formerly residing on the South (secured) unit. The findings included: 1. Closed record review for Resident #1 documented a IDT assessment dated 12/27/09, there was no documentation that the family participated in the meeting. 2. Medical record review for Resident #3 documented a IDT assessment dated 12/27/10, there was no documentation that the family participated in the meeting. 3. Medical record review for Resident #4 documented a IDT assessment dated 11/1/10, there was no documentation that the family participated in the meeting.	D 832	The facility will notify the resident(s)' family or Power of Attorney when a quarterly assessment is completed and invite them to attend the Inter-Disciplinary Team Meetings. The meeting is not manditory and they may attend if desired. If unable to attend the IDT Meeting, the quarterly assessment will be reviewed with the resident(s), designated family member or Power of Attorney by a member of the Nursing staff. The family member or Power of Attorney's signature will be obtained at that time. Date of Completion: May 15th, 2011 This will be monitored by the Quality Assurance Coordinator, Director of Nursing and the Executive Director	

Melodie Van Wye
Executive Director
4-26-11

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	TNPL537218	A. BUILDING _____ B. WING _____	C 03/30/2011

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D 832	Continued From page 12 4. Medical record review for Resident #7 documented a IDT assessment dated 11/15/10, there was no documentation that the family participated in the meeting. 5. During an interview on 3/30/11 at 12:05 PM, the Nursing Director stated, "We have never gotten those signatures in all the years I have been here..."	D 832		
D1216	1200-08-25-.12 (3)(g) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure complete nursing documentation for 5 of 7 (Resident #1, 2, 3, 4, and 5) sampled residents who were victims of sexually inappropriate behavior by Resident #7. The findings included: 1. Resident #7's Nurse Notes dated 1/21/10 documented Resident#7 was seen by a staff member inappropriately touching a female resident [Resident #1]. Staff stated resident had the female resident incontinence brief and her	D1216	The Nursing Staff will receive on going in-services which will be documented regarding importance of documenting pertinent information in the resident's medical records; especially that information regarding any unusual incident(s) or event(s). The documentation should detail: -The nature of the event(s), or -Steps taken to protect resident(s) -Physician -Family -Power of Attorney notification -Medical evalutatoin or examination performed -Outcome of the evaluation / examination Date of Completion: May 15, 2011 This will be monitored by the Director of Nursing, Executive Director and the Quality Assurance	

Melodee VanWye
Executive Director
4-26-11

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D1216	Continued From page 13 pants pulled down when he was caught fondling her. There was no documentation in Resident #1's record regarding the incident. 2. Review of Resident #7's Nurse notes dated 4/11/10 documented, Resident #2 stated while she was waiting on elevator, Resident #7 walked up behind her, turned her head to the side, grabbed her and kissed her. Resident #7 denied doing anything wrong. Review of Resident #7's Nurse notes dated 4/12/10 documented Resident #7 was inappropriately touching and trying to kiss Resident #2 against permission. There was no documentation in Resident #2's record regarding the incident. 3. Review of Resident #7's Nurse notes dated 3/4/10 documented it was reported during the quality assurance meeting Resident #7 was observed being sexually inappropriate with a female Resident #3 during an activity the day before and was observed kissing the resident on the mouth and fondling her breast. There was no documentation in Resident #3's record regarding the incident. 4. Review of the Resident Service Director's notes for Resident #7 dated 10/21/09 documented, Resident #7 was not in his apartment and that he was found in Resident #4's apartment. He attempted to go back into Resident #4's apartment 2 more times before the Resident Assistant left her shift. The RA told	D1216		

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D1216	Continued From page 14 another RA that Resident #7 was in bed with Resident #4. There was no documentation in Resident #4's record regarding the incident. 5. Review of a facility incident report dated 7/30/10 documented therapy staff reported Resident #7 was noted kissing another resident (identified by facility PT as Resident #5) inappropriately in the hallway. There was no documentation in Resident #5's record regarding the incident. 6. During an interview on 3/30/11 at 9:55 AM, the ND stated, "I do stress that there needs to be a notation in the charts...of course it should be documented."	D1216		
D1223	1200-08-25-.12 (5)(a) Resident Records (5) Plan of care. (a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident ' s legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals. This Rule is not met as evidenced by: Based on record review, document review, observation and interview, it was determined the facility failed to update the Plan of Care to include	D1223		

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D1223	Continued From page 15 interventions to effectively manage socially inappropriate and intrusive behavior for 1 of 1 (Resident #7) sampled cognitively impaired male residents who over a period of months displayed a lack of respect for private space and inappropriately touched female residents. The findings included: 1. Medical record for Resident #7 documented an admission date of 11/15/06. Diagnoses include dementia of Alzheimer type with depression and behavioral disturbance. The resident was originally admitted to the non-secure area of the facility but was moved to the South (secure) wing on 8/27/08 where he resided until 2/11/10. The Quarterly Assessment for Level of Care dated 11/2/09, 1/30/10, 5/19/10 and 8/20/10 documented the resident was independent for mobility and Psychosocial Status was circled for, "Occasional verbal direction to maintain appropriate social and personal behavior." The Quarterly Assessment for Level of Care dated 11/17/10 documented Psychosocial Status as, "Extensive intervention and supervision to manage inappropriate behavior toward self and others and to develop very basic social skills." The Plan of Care Form dated 9/16/08 documented the resident resided on the secure wing and should be checked every 2 hours. A handwritten note at the top left of the page and dated 10/22/09 documented the resident was to be checked every hour to, "Be sure he is not in someone else's apartment." There were no interventions documented to guide staff should the resident be found in another resident's apartment or should inappropriate behavior be observed.	D1223	The facility will provide documentation of on going in-services to the Nursing Staff regarding the importance of updating the resident(s)' plan of care and when changes in the resident care needs occur. This includes interventions to effectively manage socially inappropriate and intrusive behavior upon the initial onset of these behaviors. This will be documented and reported if and when they occur. Resident(s) changes will be documented in the resident(s) medical records. Also, in-services will be provided to the staff regarding the interventions to be followed and documented in the event inappropriate behaviors are observed. All in-services shall be documented and include signature of staff members to whom the in-service was provided. Date of Completion: May 15, 2011 This will be monitored by Director of Nursing, Resident Services Director, Executive Director, and the Quality Assurance Process	

Melodie Van Wyk
Executive Director
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D1223	Continued From page 16 The Plan of Care form dated 2/15/10 documented the resident resided in the non-secure area of the facility. The bottom of the page contained a handwritten note documenting, "Due to inappropriate behavior to others at times - monitor closely and document." There were no interventions documented to guide staff should the resident display inappropriate behavior. A Nurse Note dated 8/19/09 documented the resident was found in a female resident's [Resident #4] room displaying inappropriate touching. A note signed by the Resident Service Director and dated 10/21/09 documented that at "7AM ish" Resident #7 was was he was found in Resident 4's apartment. He was told to go back to his apartment and did. According to the Resident Assistant (RA) on duty he attempted to go back into Resident #4's apartment 2 times before the RA left her 7:00 AM to 3:00 PM shift. Another RA came on shift at 3:00 PM and was met in the hallway by the off going RA who stated Resident #7 was in bed with Resident #4, he had been in Resident #4's room 3 times and he had stated, "keep the incident a secret." Another entry dated 1/21/10 documented the resident was seen by staff inappropriately touching a female resident. Staff stated the resident had the female resident's (Resident #1) incontinence brief and her pants pulled down and he was fondling her. On the same day a telephone call was made to the resident's physician requesting he be sent to an inpatient psychiatric facility due to, "inappropriate sexual behavior towards a female resident ..." The resident was transferred to the psychiatric facility the same day. The Discharge Summary from the psychiatric facility dictated 2/9/10 documented Resident #7 was discharged to the medical unit	D1223		

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D1223	Continued From page 17 on 2/8/10 due to upper epigastric distress but had been stabilized prior to transfer. Discharge medications included Seroquel 100 milligrams (mg) (increased from 25 mg) at bedtime. The resident was also taking Celexa for depression and Aricept for dementia and memory. Nurse Notes dated 2/11/10 documented Resident #7 returned to the ACLF and was placed into the non-secure area of the facility. Nurse notes dated 2/13/10 documented the resident was having signs and symptoms of weakness and unsteady gait, the caregiver (RA) was instructed to hold the seroquel and Physician #1 (the attending physician) was faxed. A letter addressed to the ACLF Administrator from the Nursing Director (ND) dated 2/17/10 documented, "This is a summary of the meeting ... following my reassessment visit with [Resident #7] on 2/03/10. During this meeting we discussed whether or not [Resident #7] would be appropriate to return to the facility ... he had displayed no inappropriate behavior of any kind ... had been started on a new medication and the dosage of another medication had been increased to help alleviate and control the inappropriate behaviors ... It had been decided that [Resident #7] would be allowed to return to the facility on his the treatment he was currently receiving at the hospital ... It was also agreed upon that he would be moved from the memory impaired unit [secure wing] to the main house [non-secure area] before returning to the facility." A Nurse Note dated 2/18/10 documented the resident had a physician's appointment and the Seroquil had been decreased to 50 mg at bedtime. A Physician Visit Summary signed by	D1223		

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D1223	Continued From page 18 Physician #1 documented the Seroquel was to be decreased to 50 mg at bedtime (one half the prescribed dose at hospital discharge). Nurse Notes dated 3/4/10 documented Resident #7 "...was observed being sexually inappropriate with a female resident [Resident #3] during an activity function yesterday [3/3/10] ... was observed kissing resident on the mouth and fondling her breast ... [Physician #2] to be notified." Nurse Notes dated 4/11/10 documented Resident #2 stated when she was waiting on the elevator, Resident #7 walked up behind her, turned her head to the side, grabbed her and kissed her. The noted documented that Resident #7 denied doing anything wrong and that caregivers (RA's) were instructed to monitor the resident's behavior closely. Nurse Notes dated 4/12/10 documented Resident #7 was inappropriately touching and trying to kiss Resident #3 "against her permission." 2. Review of a facility incident report dated 1/21/10 documented Resident #7 was seen in a female resident's (Resident #1) room and that he had the female resident's incontinence brief and pants pulled down and was fondling the resident. The TYPE OF INCIDENT section of the form documented, "Sexual Assault." Review of a facility incident report dated 4/11/10 documented Resident #2 stated that while she was waiting for the elevator Resident #7 walked up behind her, grabbed her head, tuened it to the side and kissed her. The TYPE OF INCIDENT section documented, "Inappropriate behavior."	D1223		

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D1223	Continued From page 19 Review of a facility incident report dated 7/30/10 revealed therapy staff reported Resident #7 "was noted kissing another resident [identified by facility as Resident #5] inappropriately in the hallway." 3. Observations of Resident #7 on 11/2/10 at 11:03 AM, while attempting an interview with the resident, revealed he answered the door with his pants and incontinent brief down around his ankles, he stated he was coming out of the bathroom. When the surveyor offered to wait outside the door until he could pull up his pants he stated, "You can come on in." The surveyor offered again to wait outside and pulled the door closed. Resident #7 returned to the door with pants pulled up and asked, "Who are you?" After the surveyor stated her name and the purpose of the visit, Resident #7 stated, "I have no strength to talk... I don't want to talk to you." 4 During an interview on 3/30/11 at 9:30 AM, RA #1 was asked to recount what she recalled regarding incident on 1/21/10. The RA stated, "On the memory care unit in resident room, I'm doing something and I heard Resident #1 crying, went into room, Resident #1 pant is down diaper is pulled down, told Resident #7 to leave her alone...Resident #7 said 'I'm just helping her to bathroom, you don't have to help her.'.." When asked if Resident #1 was able to tell her what happened, RA #1 stated, "No is confused...just crying..." When asked if she had ever seen Resident #7 exhibit behaviors, RA #1 stated, "Just giving hugs and kisses like in a friendly way...like with [named Resident #3]..." RA #1 further stated she did not work with Resident #7 after the incident because he was moved out of the secure wing.	D1223		

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D1223	Continued From page 20 5. During an interview on 3/29/11 at 10:45 AM, the Executive Director (ED) reported the actions taken by the facility for Resident #7 was to remove him from the secure wing and counseling by nursing staff. During an interview on 3/29/11 at 2:45 PM, the ED stated the Bishop who was also Power of Attorney for Resident #7 had been to talk with him about the inappropriate behaviors, and they were considered interventions that had worked. During a subsequent interview on 3/30/11 at 10:55 AM, the ED confirmed that these meeting were not documented. During an interview on 3/30/11 at 9:55 AM, the ED was asked if Resident #7 had been provided any counseling services through the facility's gero-psych provider related to these incidents. The ED stated, "We are trying to find a Polish speaking translator... wanted to make sure he was understanding counseling ... not successful at finding anyone..." The surveyor showed the ED and ND that Resident #7 had documented counseling services in 2007 and 2008 with no interpreter required. 6. During an interview on 3/29/11 at 11:05 AM, the ND stated the Seroquel was reduced because it was making Resident #7 lethargic, it was a safety issue and Physician #1 [attending physician] reduced it to 50 mg. When asked if he had a concern regarding the medication reduction, the ND stated, "Yes, because that was what they stabilized him on in the hospital." The ND confirmed Resident #7's dose of Seroquel had remained 50 mg since the reduction on 2/18/10. During an interview on 3/29/11 at 11:30 AM, the	D1223		

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D1223	Continued From page 21 ND verified there were no reported incidents since 7/30/10. When asked how they had addressed the inappropriate behaviors with Resident #7, the ND stated, "...all along telling him you're a priest ... told him can't touch, kiss without asking ..." During an interview on 3/30/11 at 10:05 AM, the surveyor asked for documentation of the one to one counseling done by the ND with Resident #7. The ND stated there was no documentation, that it was more informal, in the hallway if maybe Resident #7 had his hands out to hug. During an interview on 3/30/11 at 10:40 AM, the ND stated, "Any behavior modification plan would have been done at the hospital [hospitalization 1/21/10] no plan in writing..." Resident #7 had documented inappropriate behavior beginning in August 2009 that continued through July 2010. The facility failed to initiate/update a Plan of Care for Resident #7 that included interventions to effectively manage his unwanted sexual advances and inappropriate sexual behaviors.	D1223		

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